Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

ACCESS MEDIQUIP LLC
2724 MONENTUM PLACE
CHICAGO IL 60689

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number:
M4-11-3760-01

MDR Date Received:
JUNE 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Invoice & letter attached from facility advising Access Mediuip will bill seperately [sic]."

Amount in Dispute: $3,060.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. Stonegate Surgery Center billed Texas Mutual for surgery services provided 8/4/10 (Attachment 1) The operative report came with the bill and nothing else. Stonegate's bill says nothing about implants. Texas Mutual paid the surgery center 235% of the Medicare amount because there was no separate request for implant payment. The payment is consistent with Rule 134.402(g). 2. The requestor submitted its billing for implants (Attachment 2) The requestor's bill contains only the bill and the invoice without any certification. (And still not certified.) Texas Mutual declined to issue payment. 3. The requestor's DWC-60 packet contains a letter dated 8/4/10, the date of service, from Stonegate Surgery Center in which the center states the requestor will bill separately for the implants. (See requestor's DWC-60 packet.) Texas Mutual has no record of receiving that letter nor has the requestor show it was submitted by the center to Texas Mutual. No payment is due for the implants."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 4, 2010	HCPCS Code L8699	$3,060.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.402 sets out the fee guidelines for Ambulatory Surgical Centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 26, 2010

- W1 – Workers Compensation State Fee Schedule Adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.
- 765 – Implant provider denied per ASC FG. Separate reimbursement for implan tables not requested by the facility per Rule 134.402(G)

Issues

1. Did the requestor submit the medical bill for the services in dispute in accordance with 28 Texas Administrative Code §134.402?
2. Did the requestor submit documentation to support the disputed bill was submitted in accordance with 28 Texas Administrative Code §134.402?

Findings

1. In accordance with 28 Texas Administrative Code 134.402(g)(1)(A-B) a facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. The facility or surgical implant provider requesting reimbursement for the implantable shall: bill for the implantable on the Medicare-specific billing form for ASCs and include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

   Review of the information provided by both parties shows the billing by the requestor was submitted on the incorrect billing form. According to the above mentioned rule, the facility or surgical implant provider requesting reimbursement for the implantable shall bill for the implantable on the Medicare-specific billing form for ASC. The correct billing form is the CMS-1500. The requestor billed the implantable on a UB-04

The insurance carrier states that the requestor's DWC-60 pack contains a letter dated 8/4/10, the date of service, from Stonegate Surgery Center in which the center states the requestor will bill separately for the implants. The insurance carrier states they have no record of receiving that letter nor has the requestor shown it was submitted by the center to Texas Mutual Insurance Company. Review of the initial CMS-1500 from the ASC did not request separate reimbursement for implants nor did the ASC submit a letter to the insurance carrier stating separate reimbursement will be requested by the implant provider.

2. Review of the documentation submitted by the requestor contains a letter from Stonegate Surgery Center dated August 4, 2010 which states in part "Stonegate Surgery Center is not and will not be billing for implants. Access MediQuip, L.L.C. will bill separately for these implants and reimbursement is to be issued directly to them." Also included in the requestors documentation was an invoice, that states "I certify that these charges are correct to the best of my knowledge" and signed by C J Brandt, from Anthrex dated August 10, 2010 which bills and ships to Stonegate Surgery Center. This invoice also includes a comment which states "THIS IS A BILL ONLY FOR ITEMS USED IN SURGERY Surgery Date: Surgery Date:Mon August 9 00:00:00 GMT+0000 2010 Provider Order ID:J7467 Comments:" It does not appear that this invoice is for the August 4, 2010 surgery date. The certification does not adhere to 28 Texas Administrative Code 134.402(g)(1)(B) as stated above. The requestor also submitted a Post-Op itemized statement for Texas Mutual Insurance Company; however, this statement
did not contain certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 22, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.